PATIENT REGISTRATION

First Name: ______________________________ Last Name: ___________________________________ Middle Initial: _________

Preferred Name: __________________________ ☐ check if guarantor is same as patient

Patient Information

Address:______________________________________ Address 2:____

City:____ State/Zip:____

Home Phone:___________________________________ Work Phone: _______________Cellular:_____________________

Sex: ☐Male ☐Female

Birth Date:_______________ Age:_______________ Social Sec:_________________

Primary Care Provider _____________________________ Do you wear? ☐glasses ☐hearing aids

What is your pharmacy of choice? ____

Guarantor

First Name:__________________________ Last name:___________________________________ Middle Initial____________

Address:_____________________________________ Address 2:____

City, State, Zip:__________________________________

Home Phone:__________________________________ Work Phone: Ext.___________ Cellular:________________________

Birth Date:___________________________________ Social Sec:_________________ Sex: Male ☐ Female ☐

Email: ____ ☐I would like to receive correspondences via e-mail.

Primary Insurance Information

Name of Insured:______________________________ Relationship to employee or student: ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec.____ Insured Birth Date: ______________________________

Employer:____________________________________ Ins. Company: ____

Address:_____________________________________ Address:____

Address 2:___________________________________Address 2:____

City, State, Zip:_______________________________ City, State, Zip:____

ID # ____

Group # ____

AR KIDS # ______________________________________

AR KIDS Effective Date ___________________________

Please send a copy of insurance card.

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